

**TEXAS HIGHER EDUCATION COORDINATING BOARD
FAMILY PRACTICE RESIDENCY PROGRAM
RURAL ROTATION**

Resident Application

Directions: Residents must complete the residency application and obtain required signatures. The resident application must be received by the Coordinating Board at least 14 business days prior to the start of the rural rotation. Residency Program Directors are responsible for forwarding completed applications and associated attachments to:

Stacey Silverman, Program Director
Texas Higher Education Coordinating Board
Attn: Family Practice Rural Rotation
1200 East Anderson Lane
Austin, Texas 78752
Phone: 512/427-6206
Fax: 512/427-6169
silvermasy@thecb.state.tx.us

Resident's Name _____ **SS#** _____

PGY Level 1 2 3
(Select one)

Residency Program _____

Residency Director & Coordinator _____

Residency Address _____

Telephone () _____ **FAX** () _____ **Email** _____

Desired Date of Rural Rotation: From _____ **To** _____

SUPERVISOR PREFERENCE

1.	_____	_____	_____
	Last Name	First Name	Location/City
2.	_____	_____	_____
3.	_____	_____	_____

This application must be accompanied by proof of licensure and malpractice coverage.

Resident's Signature

Program Director's Signature

Date

Date

RESIDENT INFORMATION

Name _____ Male _____ Married _____
Female _____ Single _____

Date of Birth _____ Place of Birth _____

Residency Director _____ PGY Level 1 2 3
(Circle one)

Residency Program _____

Resident's Address _____

Resident's Telephone _____

Medical School _____ Date of Graduation _____

Undergraduate College _____

Major _____ Date of Graduation _____

Extracurricular Activities/Hobbies

Organizations/Societies

Past Medical Experience and/or Relevant Work Experience

Please check the statement which applies to you and provide the corresponding data.

- _____ I possess a Full Texas Medical License.
Texas License Number _____
- _____ I possess an institutional, temporary, or resident license.
Institutional Permit/resident license Number _____

Malpractice Insurer

**PLEASE ATTACH A COPY OF MEDICAL LICENSE AND
FACE SHEET FROM MALPRACTICE INSURANCE POLICY.**

Please briefly describe the type of learning experience you desire from your rotation:

On the chart below, please indicate which rotations you have taken and the duration and the type (longitudinal = **L**, block = **B**, or both = **LB**) of the rotation. In the last column, please indicate with a **yes** or **no** whether your malpractice insurance through the residency program covers this type of experience.

ROTATION	<u>Duration of Experience</u> (Months, Hours, 1/2 Days, or other)	<u>Type of Experience</u> (L , B or LB)	<u>Resident/Program Malpractice Coverage</u> (Yes or No)
Human Behavior & Psych			
Community Medicine			
Geriatrics			
Disease Prevention Health Promotion			
Internal Medicine (Excluding Crit. Care/Card.)			
Cardiology			
Critical Care (ICU/CCU)			
Pediatrics			
General Surgery			
Orthopedics			
Ophthalmology			
Otolaryngology			
Urology			
Obstetrics			
Gynecology			
Emergency Medicine			
Sports Medicine			
Dermatology			
Diagnostic Imaging			
Practice Management			
Research			
Elective Time			
Other:			

Name of Resident
(Please Print)

Name of Program Director
(Please Print)

Resident's Signature

Program Director's Signature

Date _____

Date _____